Rhode Island Department of Health
Office of HIV & AIDS

HIV/AIDS Case Management Program

Request for Proposals

This Request For Proposals (RFP) provides interested Applicants with information to assist them in preparing and submitting proposals.

A Technical Assistance workshop will be held on Wednesday, June 25, 2003 from 9:30 - 10:30 am in the Health Policy Forum, 3 Capitol Hill. Call 222-2320 to register.

The Office of HIV and AIDS of the Rhode Island Department of Health (HEALTH) will make awards to qualified vendors regarding HIV Case Management services for Rhode Islanders living with HIV/AIDS

The Proposal Submission Deadline is Monday, July 21, 2003 at 1:00 pm.

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Introduction

Brief history of HIV Case Management services

The importance of providing HIV Case Management services for persons living with HIV has been evident throughout the epidemic. It is generally accepted that persons living with HIV/AIDS (PWAs) experience a delayed or less severe disease impact and are not as likely to infect others, if they are able to access and utilize comprehensive HIV Case Management services. Therefore, early in the HIV epidemic, the Rhode Island Department of Health (HEALTH) began funding HIV Case Management services. In 1993, HEALTH issued an RFP that requested proposals for an innovative "state funded targeted HIV Case Management Program". This Program has continued to fund "Targeted HIV Case Management" through contracts with vendor agencies. In 2000, Ryan White CARE Act funding was allocated for the first time to HIV Case Management services for PWAs.

Rhode Island HIV/AIDS Demographic Profile

AIDS in Rhode Island

Long-Term Trend: *Fewer newly diagnosed cases*

Since the first reported case of AIDS in Rhode Island in 1982, 2207 cases have been reported to HEALTH. The number of cases reported annually increased dramatically until 1993, then declined.

Demographic Changes: *Proportionately fewer males, Whites*

The demographics of AIDS in Rhode Island have changed over the past two decades. Although males still account for the majority of newly diagnosed cases of AIDS in Rhode Island, the majority is smaller. Whites no longer represent a majority of newly diagnosed cases, while the percentage of newly diagnosed cases attributable to Hispanics has increased significantly. In 2001 injecting drug use (IDU) was eclipsed by heterosexual contact as the most common risk factor for newly diagnosed cases of AIDS.

Disparities: *Heavier disease burden among Blacks, Hispanics*

In Rhode Island, although Whites (both male and female) represent the majority of newly diagnosed cases of AIDS, Blacks, Hispanics, and Native Americans bear a much heavier burden of disease, as revealed by average annual age-adjusted incidence rates.

HIV in Rhode Island

From 1989 through 1999, reports purposely did not contain sufficient identifying information to establish the uniqueness of an individual HIV test result with any certainty. As a result, the number of positive HIV tests received annually during this period of observation may be used only as a very rough indicator of the incidence of newly diagnosed HIV. From the year 2000 onward, reports of positive HIV test results have contained unique personal identifiers, allowing greater confidence in the interpretation of HIV data.

Demographics: *Men, persons ages 30-39 predominate; Whites, Blacks, Hispanics similar in number*

Between January 1, 2000 and May 31, 2002, 269 cases of HIV were reported in Rhode Island. The majority of cases were attributed to males and to persons between the ages of 30 and 39. The proportions of cases attributed to Whites, Blacks and Hispanics were similar. Sexual contact is clearly the most important risk factor for infection.

Disparities: *Much heavier disease burden among Blacks, Hispanics*

The present report contains the first age-adjusted HIV incidence rates computed for Rhode Island, based on counts of newly diagnosed HIV cases for 2000 and 2001. The average annual age-adjusted incidence of HIV in Rhode Island, 2000-2001, was 19.1 per 100,000 among males, and 6.9 per 100,000 among females. For both males and females, the incidence rates for Blacks and Hispanics were many times higher than the incidence rates for Whites. Asian males also had an elevated incidence rate relative to White males.

Other Sexually Transmitted Diseases

Trends: *Incidence rates up, especially notable among Hispanics*

Declining trends in the age-adjusted incidence of gonorrhea and Chlamydia reversed around 1997. By 2001 the numbers of reported cases from gonorrhea and Chlamydia had exceeded their 1992 counts. The age-adjusted incidence of both diseases increased dramatically from 1998 to 2001, particularly among Hispanics. The distribution of Chlamydia and gonorrhea among racial/ethnic groups is similar to the distribution of AIDS and HIV among racial/ethnic groups.

Rhode Island Healthy People 2010 Objectives

Rhode Island Healthy People 2010 Objectives

The provision of these HIV Case Management services should contribute to the achievement of the ***Healthy People 2010*** Goal 13, "prevent HIV infection and its related illness and death" (See Appendix A). In the Project Narrative Needs Statement, Applicants must describe how the project contributes to the 2010 Goals.

Proposal Overview

Eligible Applicants

Eligible Applicants include community-based, public or nonprofit (501c3) agencies. Applicants who submit a proposal that includes services for Medicaid enrolled PWAs must either be a current Medicaid provider or include a time-specific plan for becoming a Medicaid provider as an Attachment to the application submission. Applicants must be in good standing with the Federal and State government, in compliance with all pertinent Federal and State mandates and must be able to demonstrate fiscal stability.

Populations to be served

This Request For Proposals (RFP) requires that respondents demonstrate that they will provide a full array of HIV Case Management services. HEALTH has combined Medicaid and non-Medicaid HIV Case Management in this RFP so that clients' HIV Case Management services can continue uninterrupted if their insurance (private or public) changes. A client who has a temporary change in insurance status may thus have the option of continuing with the same agency and the same case manager. This would be possible if the agency were able to serve both Medicaid enrolled clients and non-Medicaid enrolled clients who meet the Ryan White CARE Act eligibility requirements.

This RFP includes requests for the provision of HIV Case Management services to **two** specific populations. These populations are:

- PWAs who are Medicaid enrolled, herein referred to as "Medicaid" clients
- PWAs who are **not** Medicaid enrolled, herein referred to as "non-Medicaid" clients, who meet the Ryan White CARE Act Rhode Island eligibility criteria. These criteria are:
    - Physician or Nurse Practitioner-documented HIV infection
    - Household Income below four (4) times the Federal Poverty Level ($35,920 for a single person)
    - Rhode Island residency

Available Funding

Approximately $250,000 is available annually for non-Medicaid clients and $600,000 for Medicaid clients. Funding of contracts will be contingent upon the availability of funding.

Overview of the Ryan White CARE Act

In 1990, Congress enacted Public Law 101-381, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act that was reauthorized in 1996 and again in 2000. This federal legislation directs the Health Resources and Services Administration (HRSA) to provide annual, formula-based Title II funding to State Health Departments that administer these grants. The number of AIDS cases in the State determines the annual allocation and, as noted above, Rhode Island began to allocate a portion of these monies to case management in 2000. CARE Act monies may only be used to fund services as a payor of last resort. Therefore, before providing Ryan White funded services, it must be determined that the client is not eligible for Medicaid and does not have private insurance coverage. It is allowable, however, to provide Ryan White funded HIV Case Management for a client while an insurance application is in process and when a client is temporarily disenrolled from Medicaid due to a spend down requirement.

Rate of Reimbursement to the Contractor(s)

This RFP is seeking plans for fee-for-service HIV Case Management for PWAs in one or both of the populations described above, i.e., Medicaid and/or non-Medicaid clients. The reimbursement to the providing agency will be at the rate of $60.00 per Case Management Hour.

Contract Period(s)

The Office of HIV & AIDS is requesting proposals for the provision of HIV Case Management services to Rhode Islanders living with HIV/AIDS (PWAs) for a twelve (12) month period, starting approximately August 1, 2003. HEALTH reserves the right to renew this grant on an annual basis for up to five (5) years depending on performance and availability of funding. As noted above, the Applicant may choose to submit a proposal to provide services for Medicaid enrolled clients and/or non-Medicaid clients.

Collaboration and Subcontracting

When in a collaboration, a single agency must be the lead Applicant. HEALTH strongly encourages collaboration and cooperation among agencies that are proposing to provide HIV Case Management services. The lead Applicant's proposal must describe and document such collaborative efforts. It is expected that these collaborations will be arranged so as to provide services of the highest possible quality. Collaboration should also be designed to improve or maintain access to these services for PWAs. HEALTH encourages the design of proposals that aim to achieve "100% access and 0% disparity" with respect to all services for Rhode Islanders living with HIV/AIDS. Accordingly, all proposals should include collaborative agreements that describe and document the following components of a continuum of care for PWAs:

- Access to an array of appropriate services
- Standards of case management that are maintained across agencies
- Active participation by the Applicant agency in formalized, well-established referral networks for comprehensive care
- Interagency linkage and sharing of information so that client access to services is facilitated and so that duplication of services is minimized.

Subcontracting is allowed for some program services, and the contractor is responsible for administrative oversight of all work performed by the subcontractor.

General instructions for preparation of a proposal

Proposals must be **typed** in **12CPI** or an equivalent font, in **English**, **double-spaced**, on **one side** of the page, completely **paginated** with a **one-inch** minimum **margin** on all sides and **unbound**. An **original and six (6) copies** of the completed proposal should be submitted and formatted in the order described in the Proposal Submission/ Review Checklist (Appendix B)

Additional Proposal Information

Appendix B contains an excerpt from the HRSA Glossary of HIV Related Services Categories that describes the allowable case management services to be supported with Ryan White CARE Act funding, i.e., for non-Medicaid clients. Other related policies should be viewed on the website (www.hrsa.gov) or by the following direct links: http://hab.hrsa.gov/law/dsspolicies.htm (Policies #1 and 3) and http://hab.hrsa.gov/history/habpolicies.htm (Policies 02-01, 01-01, and 00-01).

Appendix C, a list of the Components of Case Management, is to be used as a guide for program design. **It is important to note that Medicaid funded HIV Case Management allows only the "arrangement" for services. Direct services, e.g., counseling therapy, are not allowed for Medicaid clients.**

All HIV Case Management Program services and activities should be:

- Culturally sensitive, developmentally appropriate, linguistically specific
- Clearly defined with respect to target population and program objectives
- Easily accessed by the targeted population.

Proposal Outline

This section describes the proposal's contents. Your proposal should **strictly** adhere to the following outline:

1. Title Page

Include the name of the agency, FEIN number, full mailing address with zip code, e-mail address, telephone and fax numbers. In addition, include a contact person with his/her telephone number and extension. This person must be able to answer questions about the RFP.

2. Cover Letter

Include a cover letter from the agency's Board of Directors demonstrating their support for the proposal.

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Note titles and page numbers for all proposal sections and Attachments. Include the Proposal Submission Checklist (Appendix K) as Attachment 3.

4. Project Summary (Limited to two pages.)

Provide a summary of the project outlined in the proposal. List brief, but very specific information about the goals and objectives of the program. Clearly identify the population(s) [Medicaid and /or non-Medicaid] for which the Applicant is seeking to be funded. Also, include the demographic makeup of the population(s) of clients to be assisted by the program. As well as the Demographic Data about gender, race, ethnicity and age, please include the following information about the population your proposal seeks to serve: 1) location of residence, 2) housing status, 3) risk factor(s) for HIV, 4) incarceration history and status, 5) citizenship status and 6) primary language. Please note that Ryan White funded services may be provided for all persons who meet the eligibility requirements, regardless of citizenship status. The Applicant may combine the targeted population data relating to both Medicaid and non-Medicaid clients or submit separate data for each population. ***In most sections of the Proposal, the Applicant has the option to combine or separate these two populations. However, please note that the Budget Justification and Budget must clearly delineate the funding requested for each population***.

5. Agency Narrative (Limited to one page.)

Provide a brief description of the agency. The description should include:

- The type of agency
- Non-profit status (include a copy of the 501c3 statement as Attachment 1)
- An explanation of the governing structure of the agency (including the composition of the Board of Directors regarding members from minority communities),
- A brief history and general goals of the agency and the agency mission statement
- The current activities/services of the agency (include all projects related to AIDS/HIV)
- A description of the agency's prior experience with the provision of case management services

- Reasons why the agency would be an appropriate choice to receive case management funding through this RFP

6. Project Narrative (Limited to eleven pages plus the Proposal Budget Justification Form and Budget Form, Appendices D and E).

The information requested in this section is the bulk of the proposal. In this section, describe, in detail, the proposed project. Write the proposal using the following outline:

A. Needs Statement (Limited to two pages.)

Describe the target population you have identified and why this population is in need of HIV Case Management services. Describe how your agency's HIV Case Management Program will meet the need for case management services to Rhode Islanders living with HIV/AIDS. Describe how the program will contribute to the achievement of Healthy People 2010 Objective 20 (Appendix A).

B. Goals and Objectives (Limited to one page.)

List project goals and objectives. Goals should describe the general overall purpose of the program with a specific impact/outcome to be evaluated. Objectives should be specific, timely, achievable, realistic, quantifiable and documented through a process of evaluation.

C. Strategies and Activities (Limited to six pages.)

In this section describe how the objectives will be achieved by the actual day-to-day function of HIV Case Management activities. In lieu of completing any or all of the items in the outline below, the Applicant may submit an agency case management procedural manual as an Attachment and then enter specific references to this manual where the particular requirements of the outline below are addressed. The Applicant should respond to all outline topics.

Strategies and Activities Outline

1. Qualifications required for the case manager(s), (education, experience and certifications)
2. Outreach procedures that can maximize access to case management and other HIV services
3. Intake procedures – include very specific details regarding
    a. How initial contact with the agency can be made
    b. The expected average time period between this initial contact and a face-to-face encounter with a case manager
    c. Intake forms.
4. Individual Care Plan forms to be used
5. Time schedule for implementation of care plan and periodic reassessment
6. Procedures, for emergency or non-scheduled client access to case managers, including very specific time frames for response both during and outside normal agency hours
7. Sample client record and description of record keeping procedures
8. Plan for periodic quality assurance of client records as to completeness of recording and to ensure optimal client outcome
9. Planned Case Manager case loads and total planned client capacity for the Proposal
10. Supervision of Case Manager(s)
11. Training of Case Managers

D. Statement of Collaboration/Cooperation/Sub-contracts. (Limited to one page.)

Describe the formal and informal coordination of services with other agencies/individuals, especially those agencies and programs that are based within your typical service area. It is expected that the successful Applicant will actively outreach to prospective clients (prison population, HIV outpatient clinics, substance abuse treatment, mental health agencies, hospitals and private physicians) with information and support about existing resources that maximize the clients' access to a complete array of services. Please see HAB Policy Notice 01-01, the Use of Ryan White CARE Act Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons at http://hab.hrsa.gov/history/habpolicies.htm to obtain guidance regarding the non-Medicaid services allowable within the prison setting.

Because of the objective nature of the RFP review process, letters of support from clients cannot be considered. However, objective client feedback such as focus groups, client satisfaction surveys, needs assessments and/or other formal quality assurance measures from clients will be considered.

Describe any services that will be sub-contracted and provide details about the sub-contractor(s). Please attach copies of all subcontract agreements.

Letters of support or other documentation of interagency collaboration and cooperation should be included as Attachments to the proposal.

E. Evaluation (Limited to one page.)

Describe the process of outcome/impact evaluation that will measure the accomplishment of the goals and objectives listed above. Examples of existing or proposed evaluation tools should be included as Attachments to the proposal.

7. Project Administration (Limited to one page.)

Describe the overall project administration by specifying the program staff to be involved and their roles and responsibilities. Indicate the qualifications of all program staff other than the HIV case managers whose qualifications are described in Section C above. For all staff, including case managers, indicate the time (in FTEs) and other personnel information on the Budget Justification Table, Part 2 (Appendix D). Include as Attachments the resumes of all current agency staff involved in this proposal and a job description for all staff to be hired for this program.

8. Budget and Budget Justification (Use forms provided – Appendices D and E)

Complete the Budget Justification (Appendix D). In Part 1, indicate the estimated total number of PWAs to be served in the 12-month period and the estimated total amount of HIV Case Management Hours to be billed for each population served by the HIV Case Management Program. Enter the grand total of these amounts on the Proposal Budget (Appendix E, line10. Please enter amounts only on Lines, 10, 12, and 14 and enter the required 10% match.
A **Case Management Hour** is comprised of 4 units. Units are measured as follows:

- 1 unit = a contact less than 16 minutes duration
- 2 units = a contact of 16-30 minutes
- 3 units = a contact of 31-45 minutes
- 4 units = a contact of 46-60 minutes

In addition to direct contact with clients, the following services may be billed in units/Case Management Hours:

- Supervision of case managers by a qualified supervisor. Supervision sessions may include multiple case managers, but the Case Management Hours billed should be only for the real time of the Supervisor. It is expected that total supervisory time will not exceed ¼ hour/client served during a month.
- Phone calls with or on behalf of a client
- Travel time to and from a client appointment and travel time with the client. Note that when Case Manager travel time is related to multiple clients, the travel "to" will be assigned to the first client and the travel "back" will be assigned to the last client seen. It is also expected that transportation by a case manager will be provided only when another, less expensive means of transport is not appropriate or available.
- Paperwork will be related to and charged to the client. It is expected that the units of paperwork for a client will be proportional to and included within the units to be combined into a Case Management Hour, i.e., approximately 10 minutes of paperwork per Case Management Hour.

9. Description of services for racial and ethnic minority populations (Limited to one page.)

Please indicate how you will deliver culturally and linguistically appropriate services to racial and ethnic minority populations. Racial and ethnic minority populations are identified by OMB Directive 15 as: African Americans, Native Americans, Latinos/Hispanics and Asian Americans. Please include information pertaining to the following:

1. Determine an estimated number of racial and ethnic minority clients to be reached by the project.
2. Describe how the agency will access and/or outreach to the population described in number one above.

Describe how the racial and ethnic composition of the target population will be given consideration in the selection and recruitment of administrative and service delivery staff.
Describe efforts to recruit bilingual, culturally appropriate staff.
If the populations identified by OMB Directive 15 are not identified as a target population for service delivery by your proposal, provide a paragraph explaining the reasons why these populations are not an appropriate target group for your program.

Proposal Submission

Proposal Deadline

The closing date for receipt of all proposals is **(Monday) July 21, 2003 1:00 P.M**. All proposals must be received and date stamped in the Office of HIV & AIDS, Room 106, Rhode Island Department of Health, 3 Capitol Hill, Providence by this deadline. Staff that is hand-delivering proposals will be given receipts.
(Please note: The parking at the HEALTH can be difficult. Plan ahead and include sufficient time to park and deliver the proposal to the Office of HIV &AIDS.)
Applicants must hand deliver or send proposals by certified mail.
Absolutely no fax proposals will be accepted.

Proposals "received" after this date and time will be ineligible for consideration.

Proposal Preparation Technical Assistance Workshop:

All Applicants for funding through this RFP announcement are invited to attend a Technical Assistance Workshop on **Wednesday, June 25, 2003** from **9:30 to 10:30** am at the Rhode Island Department of Health Cannon Building, Three Capitol Hill, Tierney Health Policy Forum, Lower Level

Please call the Office of HIV and AIDS at 222-2320 to register for the Workshop.

Receipt, Protection, and Opening of Proposals

Proposals will be stored in a safe or locked file cabinet as they are received and shall be protected from disclosure until they are opened.

Submission Address

Submit the Original Proposal and six (6) copies to:

Rhode Island Department of Health, Office of HIV and AIDS, Three Capitol Hill, Room 106 Providence RI 02908 Attention Paul Loberti, MPH

Contact for Additional Information

For additional information about this proposal, contact Carol A. Browning, Office of HIV and AIDS 401-222-7542.

Proposed Contract Awards

Contract Requirements

The following requirements/tasks will be included in the contracts for HIV Case Management services. The successful Applicant(s) will be expected to perform the following services:

1. Provide HIV Case Management services for Rhode Islanders living with HIV/AIDS.

2. Identify an agency representative, who is directly involved in HIV Case Management, to serve on the HEALTH sponsored HIV/AIDS Provision of Care Committee.

3. Accept reimbursement for services at the rate of $60.00 per Case Management Hour. See Section 8 of the Proposal Outline for a description of this term and for a summary of billable services for activities other than face-to-face contact.

4. Provide supervision of case managers by a Master's level clinician, who can provide on-going supervision to assure quality of care. This clinician may hold a Master's level counseling or social work degree. This clinician needs to have considerable experience in a responsible position of providing services to clients with multiple issues.

5. Maintain a client record including a comprehensive, individual care plan for all HIV Case Management clients. This record will include progress notes on all services provided on behalf of the client, contacts made with the client and resources, and up-to-date assessments.

6. Obtain signed releases of information and include them in the client's record.

7. Implement confidentiality and privacy policies that assure that clients' records and other confidential information is kept in locked file cabinets and that access is limited to staff who are directly involved with client services.

8. Require that all direct service staff be knowledgeable regarding Ryan White CARE Act services that are available for PWAs and will refer clients appropriately. When possible, track referrals to determine their outcome.

9. Participate in a case management program tracking system to be designed and implement by HEALTH that will ensure that PWAs are receiving HIV Case Management services at only one agency during any one-month period.

10. Submit four **quarterly** narrative and data reports to HEALTH on forms provided by the HEALTH HIV Case Management project officer. (See Appendices F and G for sample forms)

11. Submit separate **monthly** requests for payment for non-Medicaid clients and a record of services provided for both Medicaid and non-Medicaid clients to HEALTH. The monthly reporting logs and directions for their use are Appendices H and I. Monthly reports should be submitted by the 15th of the following month, unless the HEALTH project officer grants an extension.

12. Ascertain that the HEALTH is a "payer of last resort" for all HIV Case Management Program services and verify client information with respect to other possible sources of payment for case management services, especially health insurance and managed care programs. Only clients who have no other resources for case management services are eligible for the HIV Case Management Program support.

13. Plan to deliver services over the entire contract period. Agencies must be able to provide HIV Case Management services during the entire stated contract period.

14. The Applicant shall have any and all licenses necessary to operate their facility in place prior to the start date of the Contract and for the full duration of any contract period. Further, all personnel delivering health care services shall be licensed/certified and/or registered as required bylaw.

Reports/Data:

The HIV Case Management Program contractor will provide the following two types of reports to the HEALTH Contract Manager:

1. Provide four **quarterly** reports, each comprised of a narrative and a data report on the HIV Case Management Program. Reports will be submitted to the HEALTH case management project officer on forms to be provided to the contractor by HEALTH. This report will be due at HEALTH no later than fifteen (15) days after the close of the reporting period. The narrative reports will relate to the program activities of the quarter period only. The data reports will always be **cumulative** and will be submitted for the following periods
    - **Report #1** – Due October 15, 2003 Report on clients and services provided 4/1/03 – 9/30/03 (for **continuing** contractors) or on services provided from 8/1/03-9/30/03 (for **newly funded** contractors)
    - **Report #2** – Due January 15, 2004 Report on clients and services provided in **calendar** year 2003
    - **Report #3** - Due April 15, 2004 Report on all services and clients served from 4/1/03-3/31/04

- **Report #4 -** Due July 15, 2004 Report on all services 4/1/04- 6/30/04.

Appendices F and G contain Sample Narrative and Data Reports.

2. Submit **monthly** service reports on Medicaid and non-Medicaid clients by the 15th of the month following service provision

   The **monthly** report will provide aggregate data about the types of services provided. The allowed services must be billed as follows:

   - Category 1 – Face to Face Client Services;
   - Category 2 – Phone Calls with or on behalf of the client;
   - Category 3 – Supervision of the Case Manager(s);
   - Category 4 – Travel time to and from a client appointment or travel with the client.

   Appendices H and I are Monthly Report Blanks for Medicaid and non-Medicaid clients.

All records and reports pertinent to a funded project shall be accessible to the Rhode Island Department of Health upon request.

Contract Period

Funding will be available for a five (5) year period. The first contract award period is approximately **August 1, 2003** to **July 31, 2004.** The awards may be renewed at the sole discretion of the State for four (4) subsequent periods of twelve (12) months each, based on contractor performance and availability of funding.

The Office of HIV & AIDS's Right to Award, Reject, or Negotiate Awards

The Office of HIV & AIDS reserves the right to:

- Award a contract with or without further discussions of the proposals submitted. (Therefore, proposals should be submitted initially with the most favorable cost and technical performance terms the Applicant can propose.)
- Reject any and all proposals as a result of this RFP.
- Request an oral presentation of the proposal to the Proposal Review Committee to clarify the proposal and to ensure mutual understanding.
- Arrange an on-site pre-award visit by the Office of HIV & AIDS staff to determine the Applicant's ability to meet the terms and conditions of the RFP.
- Establish a later effective date in the contract, if circumstances are such that it is in the Office of HIV & AIDS's best interest to delay it, or if funding availability is undetermined.

Review and Selection

HEALTH expects to award contracts to applicants whose proposals demonstrate conformity to this RFP's specifications with respect to the scope of services and the project cost. Applicants must possess the fiscal resources required to implement the proposed project.

The review process consists of the following steps:

- A Proposal Review Team will be comprised of representatives from the Office of HIV & AIDS and other state agencies.
- The Proposal Review Team will meet to review and discuss each proposal.
- Each proposal will receive a rating score (maximum 100 points). (The attached Proposal Evaluation Form [Appendix J] summarizes the review criteria.)
- Based upon the individual ratings assigned to each proposal by the Proposal Review Team members, the proposals will be ranked in order of priority for funding by the entire team. The applicants with the highest total scores will be offered contracts.
- The Review Team will submit the rank-ordered recommendations and overall comments to Patricia A Nolan, MD, MPH, Director of Health.

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Appendix B
CARE Act HIV Case Management Services' Description

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Appendix D
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Appendix F
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Appendix K
Proposal Submission Checklist.

Appendix A Excerpt from *Healthy People 2010*

13

HIV

Goal

Prevent human immunodeficiency virus (HIV) infection and its related illness and death.

Overview

In 1981, a new infectious disease, AIDS, or acquired immunodeficiency syndrome, was identified in the United States.[i] Several years later, the causative agent of AIDS—human immunodeficiency virus (HIV)—was discovered. This discovery coincided with the growing recognition of AIDS in the United States as part of a global infectious disease pandemic.

Currently, HIV/AIDS has been reported in virtually every racial and ethnic population, every age group, and every socioeconomic group in every State and most large cities in the United States.[ii] Initially identified among men who have sex with men on the East and West Coasts,[iii] the AIDS epidemic is composed of diverse multiple subepidemics that vary by region and community. By the end of 1998, more than 680,000 cases of AIDS had been reported, and nearly 410,800 people had died from HIV disease or AIDS.

Healthy People 2010 Objectives

13-1. Reduce AIDS among adolescents and adults.

13-2. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.

13-3. Reduce the number of new AIDS cases among females and males who inject drugs.

13-4. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men and inject drugs.

13-5. Reduce the number of cases of HIV infection among adolescents and adults.

13-6. Increase the proportion of sexually active persons who use condoms.

13-7. Increase the number of HIV-positive persons who know their serostatus.

13-8. Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.

13-9. Increase the number of State prison systems that provide comprehensive HIV/AIDS, sexually transmitted diseases, and tuberculosis (TB) education.

13-10. (Developmental) Increase the proportion of inmates in State prison systems who receive voluntary HIV counseling and testing during incarceration.

13-11. Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.

13-12. Increase the proportion of adults in publicly funded HIV counseling and testing sites who are screened for common bacterial sexually transmitted diseases (STDs) (chlamydia, gonorrhea, and syphilis) and are immunized against hepatitis B virus.

13-13. Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines.

13-14. Reduce deaths from HIV infection.

13-15. (Developmental) Extend the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase years of life of an individual infected with HIV.

13-16. Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death.

13-17. Reduce new cases of perinatally acquired HIV infection.

Appendix B CARE Act HIV Case Management Services' Description

Excerpted from the "Glossary of HIV Related Services" available at www.hrsa.gov

Case Management:

A range of client-centered services that link clients with health care, psychosocial and other services. Ensures timely, and coordinated access to medically appropriate levels of health and support services, continuity of care, through ongoing assessment of the client's and other family members' needs and personal support systems. Also includes inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include (1) initial assessment of the service needs, (2) development of a comprehensive, individualized service plan, (3) coordination of the services required to implement the plan as well as client monitoring to assess the efficacy of the plan, and (4) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. May include client specific advocacy and/or review of utilization of services

Appendix C Components Of Case Management

The following are the expectations associated with HIV Case Management. HIV Case Management has evolved in response to the need to facilitate access to services with HIV positive clients. Functionally, case management is a multi-step process that encompasses the following range of activities:

1.information and referral
2.intake and assessment
3.service planning and implementation
4.ongoing monitoring and reassessment of care needs, and
5.supervision of direct service staff by qualified agency supervisory personnel.

In addition, the cultural competency of service providers is a critical component of these services.

Information and Referral

Information and support about existing resources available to people affected by HIV/AIDS is essential in order to maximize access to services. The staff and others providing these services not only need to know what services are available, but also need to know the eligibility requirements and application procedures so that they can give accurate instructions to clients trying to obtain services. This may include outreach to prospective clients (prison population, HIV out patient clinics, substance abuse treatment, mental health agencies, hospitals and private physicians) with information and support about existing resources that maximize access to services.

The range of referrals available must include the resources for the following services:

- **Substance Abuse Treatment**: detox programs (public and private), residential and day treatment, methadone treatment, outpatient counseling, acupuncture treatment, self-help groups
- **Housing**: permanent, transitional, low-income, and group housing alternatives
- **Medical Care**: primary care, hospital services, specialty and dental care
- **Financial Assistance and Entitlement programs**: Ryan White CARE Act Title II funded programs, Social Security, GPA, AFDC, food stamps, fuel assistance
- **Food Assistance**: food pantries, congregate meals, home delivered meals programs
- **Insurance**: COBRA law, health insurance, Medicaid, disability insurance, life insurance
- **Legal assistance**: affordable legal resources to provide assistance with estate planning, discrimination, immigration, and bankruptcy
- **Home Health**: nursing services, home health aides, homemakers, personal care attendance
- **Practical Support**: transportation, laundry, shopping, meal preparation, housekeeping
- **Mental Health Services**: individual and family counseling, support groups, peer support, buddy programs, crisis intervention and back-up for psychiatric emergencies, pastoral counseling, secondary prevention counseling.
- **Long -Term Care**: chronic care facilities, hospice care, clinical trials
- **Child Care**, foster care, adoption and guardian ship
- **Rehabilitative Services**: vocational, physical
- **Holistic Therapies:** acupuncture, herb medicine, nutrition counseling, wellness, homeopathic medicine, yoga
- **Information about HIV Treatments:** out patient clinics and local physicians who specialist in HIV treatment
- **Funeral Services:** family bereavement services. ***Note Payment for Funeral Services is not allowed by the CARE Act requirements.***

Intake and Assessment

An initial assessment should occur within a reasonable amount of time, 48-72 hours after the first contact. During the initial assessment, the role of the case manager should be explained, and the client should be requested to sign consent forms which gives the case manager permission to interact with the key professionals, volunteers, friends and family members involved. The client must sign a form consenting to services from the agency acknowledging understanding of the ongoing involvement of the case manager and an understanding that the agency will maintain confidential records on the client. Client records need to have appropriate documentation showing the client understands the content of the care plan and has signed a release of information form.

The purpose of the initial assessment is to accurately evaluate their client's situation in order to identify his/her health and social service needs. The assessment involves the collection of information in a sensitive manner regarding the client's drug treatment, medical, psychological, and social circumstances in order for the case manager to be aware of the client's functional abilities and resources.

A comprehensive assessment would include the following areas:

Drug and Alcohol Use

1. History of drug and alcohol use and signs of adverse effects on client's interpersonal relationships and functional abilities.

2. Current need for treatment/detoxification
3. Past or current treatment: motivation and environmental support to remain in recovery.

Medical/physical

1. Medical history and current symptoms
2. Current medical treatments; use and understanding of prescribed medications
3. Understanding of modes of transmission and need for health education
4. Nutrition

Psychological

1. Psychiatric history and current counseling
2. Coping mechanisms and ability to manage stress
3. Suicidal ideation
4. Indications of dysfunction (mood swings, psychotic features, sleep disturbances, depression, anxiety, mania).

Social/Spiritual

1. Sources and quality of emotional and practical support
2. Quality of relationships with partner, friends, and family
3. HIV status of client's primary supports or dependents
4. Need for support services for partner, friends and family
5. Spiritual and religious needs

Financial

1. Source and level of income
2. Ability to remain employed or enter employment
3. Health insurance coverage
4. Eligibility for entitlement programs: Medicaid, general relief, AFDC, Social Security, food stamps, housing subsidies, HIV Drug Reimbursement Program.

Housing

1. Adequacy of current living arrangement
2. Need for emergency shelter or specialized housing

Ability to maintain independence

1. Ability to maintain personal hygiene
2. Ability to maintain home and personal possessions
3. Ability to shop for and prepare food
4. Access to and ability to use public and private transportation

Legal

1. Estate Planning
2. Designated power-of-attorney for medical and financial decisions
3. Living will
4. Issues around immigration

Service Linkages

1. Identification of other agencies providing services which need to be included in coordination of care planning:
2. Drug treatment program
3. Primary physician and hospital
4. Home care agency involved
5. Mental health services
6. Social service agencies
7. Client's experiences trying to access services and adequacy of service received

Identification of barriers to service

1. Language/culture
2. Behavioral/psychological (fear of disclosure, active substance abuse, etc.)
3. Physical
4. Financial

Service Planning and Implementation

A comprehensive, individual care plan is developed for each client based on the needs identified in the initial assessment described above. The care plan is the translation of assessment information into specific treatment goals and objectives, and should be developed collaboratively with the client and with input from other providers as appropriate. The care plan should specify short and long-term goals, actions needed to address each goal, the specific services needed and referrals to be made, and any other factors that will impede the implementation of the goals. The plan should also delineate time -frames for reaching the goals and for necessary follow-up. The range of services that need to be considered when formulating the service plan are the same as listed above.
Documentation should include:

- Description of the problem(s)

- Short and longer term goals for each problem
- Resources/services to meet each need
    1. Client's resources and support network
    2. Nature and level of service need
    3. Time -frames that the services will be provided
    4. Provider of service
- Notes on the availability and appropriateness of each service and alternative plans.
- The client's signature on the care plan, documenting their agreement and understanding of the content of the care plan.

Implementation of the service plan requires that the case manager assists the client in following through on referrals, applying for services, and negotiating the delivery of services as needed. Documentation of efforts to implement the care plan should include weekly summary notes describing actions to obtain services, frequency of contacts, outcome or status of efforts to obtain services and plans for continued follow-up, if indicated.

Ongoing Coordination, Monitoring and Periodic Reassessment of the Care Plan

Monitoring refers to the periodic follow-up contact with each client, as indicated by the service plan. Monitoring may be contact by telephone or in person and noted in the care plan with dates and nature of the contact. Support persons and service providers contacted should also be documented in the care plan. QA/QC should be conducted on a semi-annual basis by the supervisory staff.

Every client being followed by a case manager should meet with the case manager **at least** monthly to reevaluate the care needs and revise the care plan as necessary. A reassessment should occur whenever a change in the client's status occurs which significantly affects his/her care needs. The events would include but not be limited to a drug positive urinalysis, serious illness, hospitalization, loss of income, or loss of stable housing.

Supervision of Direct Service Staff by Qualified Agency Supervisory Personnel

Qualified agency supervisory staff should be a Master's level clinician, who holds a counseling or social work degree and can provide on-going supervision to assure quality of care. This clinician needs to have considerable experience in a responsible position of providing services to clients with multiple issues. This clinician will be responsible for:

- Weekly supervision sessions with case managers
- Quality review of client files
- Informing case managers when information, forms and notes are missing from client files.

Appendix D HIV Case Management Services Budget Justification

Part 1 Direct Services Cost

1.Case Management Services for _____**(estimated)** Non-Medicaid clients,
@ $60/hour _____Case Management hours = $_____

2.Case Management Services for _____**(estimated)** Medicaid clients,
@ $60/hour_____ Case Management Hours = $ _____

Part 2 Listing of all HIV Case Management Program Staff

Name	Position/Title	Total Annual Salary and Fringe	Hours in FTEs Devoted to HIV Case Management Program	Hours in FTEs devoted to non-Case Management Program duties

Appendix E Budget Form

12-Month Budget

The Contractor estimates that its budget for work to be performed for a twelve (12) month period under this Agreement is as follows:

Expense Category		Estimated Expenditures
1. Direct Services Fees ……..……..…..…		$ _____
Medicaid Subtotal	$_____	
Non-Medicaid Subtotal	$_____	
2. TOTAL		$ _____

Required match of at least 10% $_____
Please indicate source of in-kind match.

Appendix F ***Sample*** **HIV Case Management Program**
Quarterly Narrative Report

Contractor: _____
Report Period: From_____to_____

1. Please describe the progress and problems in the HIV Case Management Program during the reporting period.

2. Please describe any Staff changes affecting the HIV Case Management Program.

3) Other comments:

Agency Signature:_____ Date: _____

Appendix G *Sample* HIV Case Management Program Quarterly Demographic Report

Contractor: _____

Report Period: _____ to_____

Please note: Insert aggregate counts of all HIV Case Management Program clients who were served in the reporting period and the total hours of services provided. Submit the signed and dated report to the HEALTH Contract Officer. These data will be used to complete the Title II Progress Reports and the Annual Administrative Report (AAR) for the Health Resources and Services Administration (HRSA).

Total Clients Served	Gender	Age	Household Income	Race Ethnicity		Housing Status	Medical Insurance	HIV/AIDS Status	Clients' Vital/enrollment status at end of reporting period
Total clients Served _____ **NEW** Clients since last report ____	Male _____ Female _____ Transgender _____ Other _____	<2 years _____ 2-12 years _____ 13-24 years _____ 25-44 years _____ 45-64 years _____ Over 65 _____	< Or = FPL _____ 101-200%FPL _____ 201-300% FPL _____ >300 % FPL _____	Hispanic or Latino/a _____ Non-Hispanic or Non-Latino/a _____	White _____ Black/African American _____ Asian _____ Hawaiian/ Pacific Islander _____ American Indian/ Alaskan Native _____ More than one race _____	Permanently/Stably housed (rent or own) _____ Non-Permanently housed _____ Institution _____ Other _____	Private _____ Medicare_____ Medicaid _____ Other Public _____ No Insurance _____ Other _____	HIV+, not AIDS _____ HIV+, AIDS Status Unknown _____ CDC-Defined AIDS _____ HIV- (affected) _____ Unknown _____	Active, client new to program _____ Active, Client continuing in Program _____ Deceased _____ Inactive _____ Unknown/Unreported _____

Total Case Management Hours Provided during the reporting period: _____Case Management Hours

Agency Signature: _____ **Date:** _____

Appendix H ***Sample*** **Monthly Medicaid Report**

Agency _____ Billing Period _____

MEDICAID CLIENTS						
Client Code	**Primary Case Manager**	**Service Codes ***				
		1	**2**	**3**	**4**	**Total Units**
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
Total Service Units for Medicaid Clients		**0**	**0**	**0**	**0**	**0**
Total Case Management Hours for Medicaid Clients					**0**	
**** fill in the number of service units for each code: 1 unit = 1-15 minutes***						
Agency Signature _____Date_____ Page___of ___						

Code 1 Face-to-Face Client Services
Code 2 Phone calls with or on behalf of a client
Code 3 Supervision of Case Manager(s)
Code 4 Travel time to and from a client appointment and travel time with the client

Appendix I ***Sample*** **Monthly Non-Medicaid Report**

Agency _____ Billing Period_____

Non-MEDICAID CLIENTS						
Client Code	**Primary Case Manager**	**Service Codes ***				**Total Units**
		1	**2**	**3**	**4**	
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
						0
Total Service Units for Non-Medicaid Clients		**0**	**0**	**0**	**0**	**0**
Total Case Management Hours for Non-Medicaid Clients					**0**	
**** fill in the number of service units for each code: 1 unit = 1-15 minutes***						
Agency Signature _____Date_____ Page___of ___						

Code 1 Face-to-Face Client Services
Code 2 Phone calls with or on behalf of a client
Code 3 Supervision of Case Manager(s)
Code 4 Travel time to and from a client appointment and travel time with the client

Appendix J

Proposal Evaluation Form

Total Score _____ (Maximum 100)

Applicant Agency _____Reviewer_____

Please score the proposal using the criteria below.

____ Points (0-10)	Proposal includes and conforms to all the requirements stated in the Request for Proposals, including a response to all the items in the Proposal Outline.
____ Points (0-10)	Applicant agency demonstrates the capacity to provide appropriate HIV Case Management services.
____ Points (0-10)	Applicant demonstrates experience with, knowledge about and access to the Rhode Island PWA population.
____ Points (0-10)	The RFP describes appropriate qualifications, training and supervision of HIV case managers.
____ Points (0-5)	The Project Narrative includes an appropriate Needs Statement
____ Points (0-5)	The Goals, Objectives are realistic and measurable.
____ Points (0-15)	The Applicant submitted all the elements of the Strategies and Activities Outline and the submission demonstrates that the Agency can adhere to a high standard of HIV Case Management. The Project Administration ensures that a high standard of HIV Case Management Program quality will be maintained
____ Points (0-5)	Planned collaboration, cooperation and referrals are described and appropriate Letters of Support as included as Attachments.
____ Points (0-5)	The evaluation plan will be able to measure outcome and impact of the HIV Case Management Program.
____ Points (0-5)	The Budget Justification and Budget Forms are complete and realistic.
____ Points (0-10)	The Applicant demonstrates fiscal and programmatic stability such that the agency will be able to continue targeted HIV Case Management services during the entire contract period.
____ Points (0-10)	If the Applicant proposes to provide services for Medicaid clients, the Applicant is a currently a Medicaid provider or the Applicants submits a realistic plan for becoming a Medicaid provider in the near future. Applicants that submit a proposal to serve only non-Medicaid clients should include plans for clients to have uninterrupted access to case management services if the client becomes enrolled in Medicaid.

Appendix K

PROPOSAL SUBMISSION/REVIEW CHECKLIST

Attach this list as Attachment 3 of your proposal.

_____1.Name of agency representative(s) who attended the Technical Assistance Workshop_____

_____2.Proposal is written according to the "General Instructions for Preparation".

_____3.All information requested in the proposal is provided.

_____4.Proposal is submitted in the proper sequence adhering to the following outline:

- _____Title Page
- _____Cover Letter from Board of Directors
- _____Table of Contents
- _____Project Summary
- _____Agency Narrative
- _____Project Narrative
  - _____Needs Statement
  - _____Goals and Objectives
  - _____Strategies and Activities
  - _____Statement of Collaboration/Cooperation/Sub-contracts
  - _____Evaluation
- _____Project Administration
- _____Budget and Budget Justification
- _____Description of services for racial and ethnic minorities
  - _____Attachment 1 - Copy of 501c3 document
  - _____Attachment 2 - Letter(s) of Support/Documentation(s) of Collaboration
  - _____Attachment 3 – Proposal Review/Checklist
  - Other Attachments, if any

_____5. Original proposal and six (6) copies are included in submission package.

REQUEST FOR PROPOSALS
HIV CASE MANAGEMENT SERVICES

The Rhode Island Department of Health (HEALTH), Office of HIV & AIDS, is soliciting proposals from agencies to provide HIV Case Management services for Rhode Islanders who are living with HIV infection or AIDS.

The RFP is available at www.HEALTH.ri.gov or a copy of the RFP may be obtained by calling the Office of HIV & AIDS at 401/222-2320 during HEALTH business hours (8:30 a.m. - 4:30 p.m.).

A Pre-proposal Technical Assistance Workshop will be held on Wednesday June 25, 2003 from 9:30 to 10:30 a.m. at HEALTH. Please RSVP for the Technical Assistance Workshop at 401-222-2320.

The proposal submission deadline is Monday, July 21, 2003 at 1:00 p.m. Submit proposals to:

Paul Loberti, Chief Administrator
Rhode Island Department of Health
Office of HIV & AIDS, Room 106
3 Capitol Hill
Providence RI 02908.